









MHS Prior Authorizations





Agenda

-  Prior Authorization (PA)
-  Online Prior Authorization Tool
-  What You Need to Know
-  Online Provider Portal Services
-  Telephonic and Fax Authorizations
-  Appeals Process
-  MHS Team
-  Questions and Answers

Prior Authorization


Prior Authorization


MHS Medical Management will review state guidelines and clinical documentation. Medical Director input will be available if needed.

-  PA for observation level of care (**up to 72 hours for Medicaid**), diagnostic services do not require an authorization for contracted facilities.
-  If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.

Prior Authorization





Inpatient Services:

 MHS no longer accepts phone calls and only accepts notification of an inpatient admission via fax, using the IHCP universal prior authorization form, or via the MHS Secure Provider Portal.

 Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.

Prior Authorization



Outpatient Services:

-  All elective procedures that require prior authorization must have request to MHS at least **two business days** prior to the date of service.
-  All ER services do not require prior authorization, but admission must be called into MHS Prior Authorization Department within **two business days** following the admit.
-  Members **must** be Medicaid Eligible on the date of service.
-  Prior Authorizations are not a guarantee of payment.

Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims.














Prior Authorization

Transfers:

-  MHS requires **notification and approval** for all transfers from one facility to another at least two business days in advance.
-  MHS requires **notification** within two business days following all emergent transfers. Transfers include, but are not limited to:
 - Facility to facility
 - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain.

Prior Authorization

Services that require prior authorization regardless of contract status:

-  Injectable drugs (see mhsindiana.com/provider-guides for up-to-date list of codes)
-  Nutritional counseling (unless diabetic)
-  Pain management programs, including epidural, facet and trigger point injections
-  PET, MRI, MRA and Nuclear Cardiology/SPECT scans
-  Cardiac rehabilitation
-  Hearing aids and devices
-  Home and Institutional hospice (coverage varies by product)
-  In-home infusion therapy
-  Orthopedic footwear
-  Respiratory therapy services
-  Pulmonary rehabilitation
-  Home care (except after an IP admission with benefit limitations)
-  Physical Therapy, Occupational, and Speech Therapy

- MHS website:
mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers

You can find out more about the information in this table in the MDS Provider Manual, www.mdsinfo.com/provider/manual, or by contacting HIE at 1-877-CO-3333.



Online Prior Authorization Tool

Medicaid Pre-Auth Needed?

Become a Provider

CLAS Standards

MHS Provider
Webinars

Partnered Member
Events

Pharmacy Benefits
Information for
Providers

Prior Authorization

Transactions

PaySpan Health

POWER Account
Resource Center

Provider Information
Resource Center

Provider Guides

Dental Providers

Presumptive
Eligibility

Quality
Improvement

HEDIS®

Practice Guidelines

Immunization
Information

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the [provider manual](#). If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Envolve Vision](#)

Complex Imaging, MRA, MRI, PET and CT scans need to be verified by [NIA](#)

Hoosier Healthwise dental services need to be verified by [State](#)

Healthy Indiana Plan (HIP) and Hoosier Care Connect dental services need to be verified by [Envolve Dental](#)

Ambulance and Transportation services need to be verified by [LCP Transportation](#)

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

Non-participating providers must submit Prior Authorization for all services
For non-participating providers, [Join Our Network](#).

Are Services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

YES ☐ NO ☐

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input type="radio"/>

Online Prior Authorization Tool

Types of Services

	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving dialysis?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

Check

N
No

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

What You Need to Know

Self-Referral Services

Exceptions to prior authorization requirements.




Members can see these specialists and get these services without a direct referral from their PMP:

- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self management

****Benefit limitations apply***

National Imaging Associates (NIA)

Physical, Occupational and Speech Therapy

-  Utilization management of these services is managed by NIA.
-  Prior authorization for PT, OT, and ST services is required to determine whether services are medically necessary and appropriate; determination is made by MHS not NIA.
-  All Health Plan approved training/education materials are posted on the NIA website, www.RadMD.com. For new users to access these web-based documents, a RadMD account ID and password must be created.

Chiropractors rendering therapy services are exempt from the NIA program.

NIA

Outpatient Radiology PA Requests

 MHS partners with NIA for outpatient Radiology PA Process

 PA requests must be submitted via:

- NIA Web site at RadMD.com
- 1-866-904-5096

****Not applicable for ER and Observation requests***

Durable & Home Medical Equipment

Requests should be initiated via **MHS secure portal**.






Prior authorization required by the **ordering physician** for all non-participating DME providers.

- **Web Portal:** Simply go to mhsindiana.com, log into the Secure Provider Portal, and click on “Create Authorization.” Choose DME and you will be directed to the Medline portal for order entry.
- **Fax Number:** 1-866-346-0911
- **Phone Number:** 1-844-218-4932

Turning Point


Musculoskeletal Safety & Quality Program

MHS has entered into an agreement with Turning Point Healthcare Solutions, LLC to implement a Musculoskeletal Safety and Quality Program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.

-  Emergency Related Procedures do not require authorization.
-  It is the responsibility of the ordering physician to obtain authorization.
-  Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.
-  Clinical Policies are available by contacting TurningPoint at 574-784-1005 for access to digital copies.
-  **TRAINING:** Informational webinars are available! Please register at: <https://register.gotowebinar.com/rt/7079530369468972290>.

Turning Point

Cardiovascular Authorizations

 Effective May 1, 2020 Managed Health Services has delegated its utilization management function to TurningPoint for cardiac services. The physician/providers office who requests the procedure should request the prior authorization.

 **Services that require prior authorization:**

Cardiac Surgical Procedures:
Automated Implantable Cardioverter Defibrillator
Leadless Pacemaker
Pacemaker
Revision or Replacement of Implanted Cardiac Device
Coronary Artery Bypass Grafting (Non Emergent)
Coronary Angioplasty and Stenting
Non-Coronary Angioplasty and Stenting

 **Emergent surgeries do not require a prior authorization.**




- Web Portal Intake: myturningpoint-healthcare.com Telephone Intake: 574-784-1005 | 855-415-7482

PA Documentation Needed




Bariatric Surgery:

-  Must include cardiac workup, pulmonary workup, diet and exercise logs, current lab reports, and psychologist report.

Pain Management:















-  Must have documentation of at least six weeks of therapy on area receiving treatment.
-  Include previous procedures/surgeries, medications, description of pain, any contra-indications or imaging studies.
-  Include prior injection test results for injection series.

Home Health:

-  Physician's orders and signed plan of care, including most recent MD notes about the issue at hand.
-  Home care plan, including home exercise program.
-  Progress notes for medical necessity determination.

Sub Acute Care




Managed Health Services (MHS) provides health coverage for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect. MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every 3-5 days. It is important that you provide a complete current clinical update on our member's status at each review.

-  The review should include current information (within one day) on:
 -  Member's condition
 -  Level of functioning (prior to admission)
 -  Medications
 -  Therapies provided
 -  Participation in therapies
 -  Progress toward goals
 -  New or amended goals
 -  Updates from care conferences
 -  Updates to our member's plan of care
 -  Discharge plans and needs identified (home health/DME, etc.)
 -  Anticipated discharge date
-  Indiana Code requires that individuals requesting a nursing facility admission to a Medicaid-certified NF meet a nursing facility level of care (*405 IAC 1-3-1* and *405 IAC 1-3-2*). A PASRR is required before admission and must be submitted with the admission request and when updated according to IAC requirements.
-  Please submit this information as requested by MHS nurse reviewer every 3-5 days.

Prior Authorization (PA) Request


MHS strives to return a decision on **all** PA requests within **two business days** of Request. Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes to:

-  Dates of Service
-  CPT/HCPCS codes
-  Provider MHS has up to **seven days** to render PA decisions.

-  PA approval requires the need for medical necessity.
-  Medical Management **does not** verify eligibility or benefit limitations: Provider is responsible for eligibility and benefit verification
-  ***Denied Authorizations*** must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.

****Providers may make corrections to the existing PA as long as the claim has not been submitted.***

Continuity of Care PA Request

 MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request.

**Reference: MHS Provider Manual Chapter 6*


Pharmacy Requests

MHS Pharmacy Benefit Manager is Envolve

Envolve Pharmacy Solutions:

 Preferred Drug Lists and authorization forms are available at mhsindiana.com/provider/pharmacy:

- PA requests
- Phone 1-866-399-0928
- Fax non specialty drugs 1-866-399-0929
- Specialty drugs 1-866-678-6976
- pharmacy.envolvehealth.com

 Formulary integrated into many Electronic Health Records (EHR) solutions

 Online PA submission available through CoverMyMeds:

- covermymeds.com

 Online PA forms for Specialty Drugs on mhsindiana.com

Behavioral Health Prior Authorization

Facility Services Requiring Prior Auth:

- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Partial Hospitalization SUD Residential Treatment

Behavioral Health Prior Authorization

Prior Authorization Professional Services Requiring Prior Auth:

Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month rolling year without authorization)

Behavioral Health Outpatient Therapy “BHOP Therapy” (Limited to 20 visits per member, per practitioner, per 12 month rolling period)

Electroconvulsive Therapy

Psychological Testing

- Unless for Autism: then no auth is required

Developmental Testing, with interpretation and report (non-EPSDT)

Neurobehavioral status exam, with interpretation and report

Neuropsych Testing per hour, face to face

- Unless for Autism: then no auth is required
- Non-Participating Providers only

ABA Services

Behavioral Health Prior Authorization

- Please call MHS Care Management for inpatient and partial hospitalization authorizations at 1-877-647- 4848.
- MHS Authorization forms may be obtained on our website:
<https://www.mhsindiana.com/providers/behavioral-health/bhprovider-forms.html>
- Outpatient Treatment Request (OTR) Form; Fax: 1-866-694-3649
- Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency - Fax: 1-866-694-3649
- Applied Behavioral Analysis Treatment (OTR) - Fax: 1-866-694-3649
- Psychological & Neuropsych Testing Authorization Request Form - Fax: 1-866- 694-3649
- Residential/Inpatient Substance Use Disorder Treatment Prior Auth Form –
- Fax Inpatient: 1-844-288-2591; Fax Outpatient: 1-866-694-3649
- If using the IHCP Universal form, please fax to the numbers listed above to reduce fax transfers.

Behavioral Health Prior Authorization

Limitations on Outpatient Mental Health Services

Effective 12/15/18, Managed Health Services (MHS) has begun applying this limitation for claims with dates of service (DOS) on or after 12/15/18. Claims exceeding the limit will deny EX Mb: Maximum Benefit Reached.

- If the member requires additional services beyond the 20 unit limitation, providers may request prior authorization for additional units. Approval will be given based on the necessity of the services as determined by the review of medical records.
- Providers will need to determine if they have provided 20 units to the member in the past rolling 12 months (starting with DOS 12/15/18) to determine if a prior authorization request is needed.
- “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).
- This change is related to professional services being billed on CMS 1500.

MHS Secure Provider Portal

Web Portal Authorizations

 Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login:

- When using the portal, providers can upload supporting documentation directly.

 **Exceptions**: Must submit Inpatient, hospice, home health and biopharmacy PA requests via **fax 1-866-912-4245**

 Providers can check the authorization status on the portal.

Secure Portal Registration and Login



[Home](#) [Find a Provider](#) [Portal Login](#) [Events](#) [Contact Us](#)

Contrast ☐ On ☒ Off language▼

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Prior Authorization +

Dental Providers

Pharmacy +

Provider Resources +

QI Program +

Provider News

Portal Login

Login/Register

[Click here for more information](#) on the Provider Portal functions and training documents.

Behavioral Health Secure Portal

[Click here for the Cenpatco behavioral health portal.](#)

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login button. A new window will open. You can login or register.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Registration

Registration Complete!

Your Progress 

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

Login



Features Join Our Network CREATE ACCOUNT

The Tools You Need Now!

Our site has been designed to help you get your job done.

For registration or secure website questions call (866) 912-0327.

Manage all products with ease in one location



Check Eligibility

Find out if a member is eligible for service.



Authorize Services

See if the service you provide is reimbursable.



Manage Claims

Submit or track your claims and get paid fast.

Login

User Name (Email)

name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register

Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF



Eligibility Patients Authorizations Claims Messaging Help

Provider Name

Viewing Dashboard For: Tax ID Number Medicaid GO

Quick Eligibility Check

Member ID or Last Name




123456789 or Smith

Birthdate

mm/dd/yyyy

Check Eligibility

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	C	4
	08/19/2017	T	3
	08/19/2017	E	1
	08/19/2017	F	8

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

Recent Activity

Date

Activity


Quick Links







[Provider Resources](#)

Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.

Authorizations:

 View, create and filter group authorizations



 Eligibility
  Patients
  Authorizations
  Claims
  Messaging
  Help

Viewing Authorizations For :

Authorizations

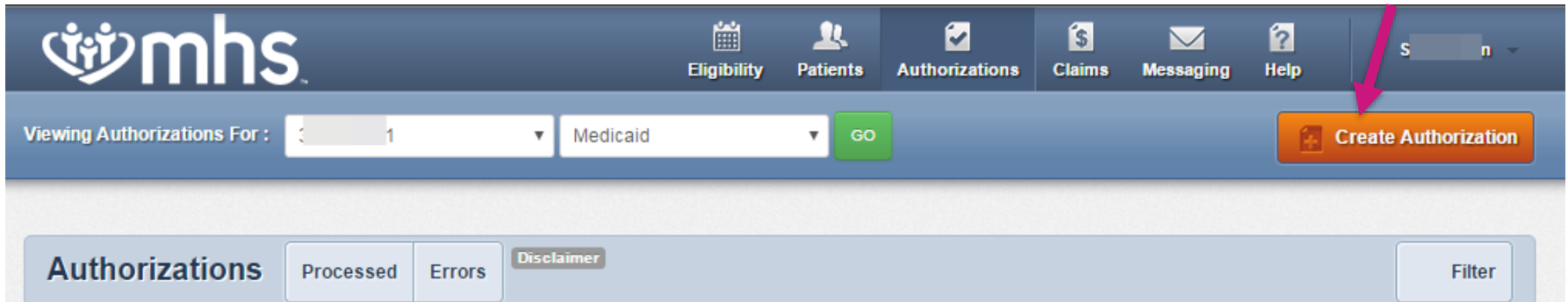
Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	O [REDACTED] 1	Al [REDACTED] H	07/24/2017	10/24/2017	E11.9	OUTPATIENT	DME
<input type="button" value="PARTIAL_APPROVE"/>	C [REDACTED] 9	[REDACTED] V	06/14/2017	09/19/2017	B07.9	OUTPATIENT	Office Visit

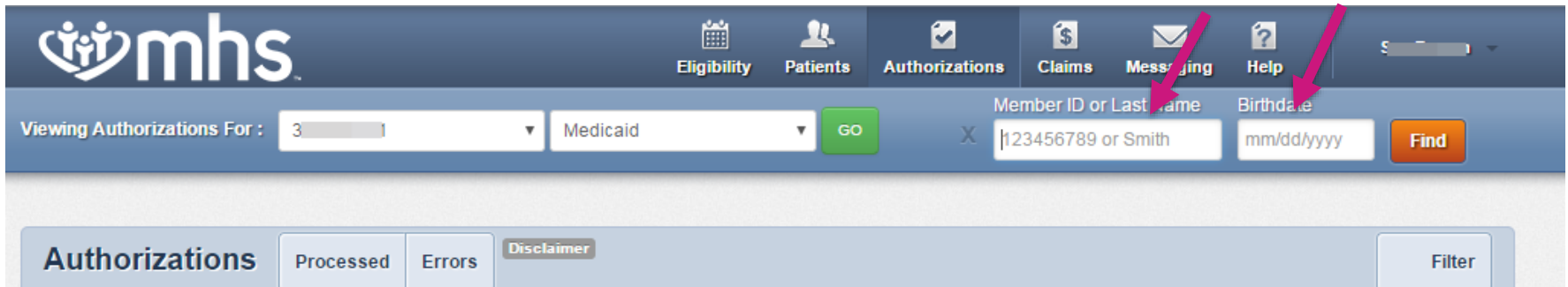
Creating a New Authorization

 Click **Create Authorization**.

 Enter **Member ID** or **Last Name** and **Birthdate**.



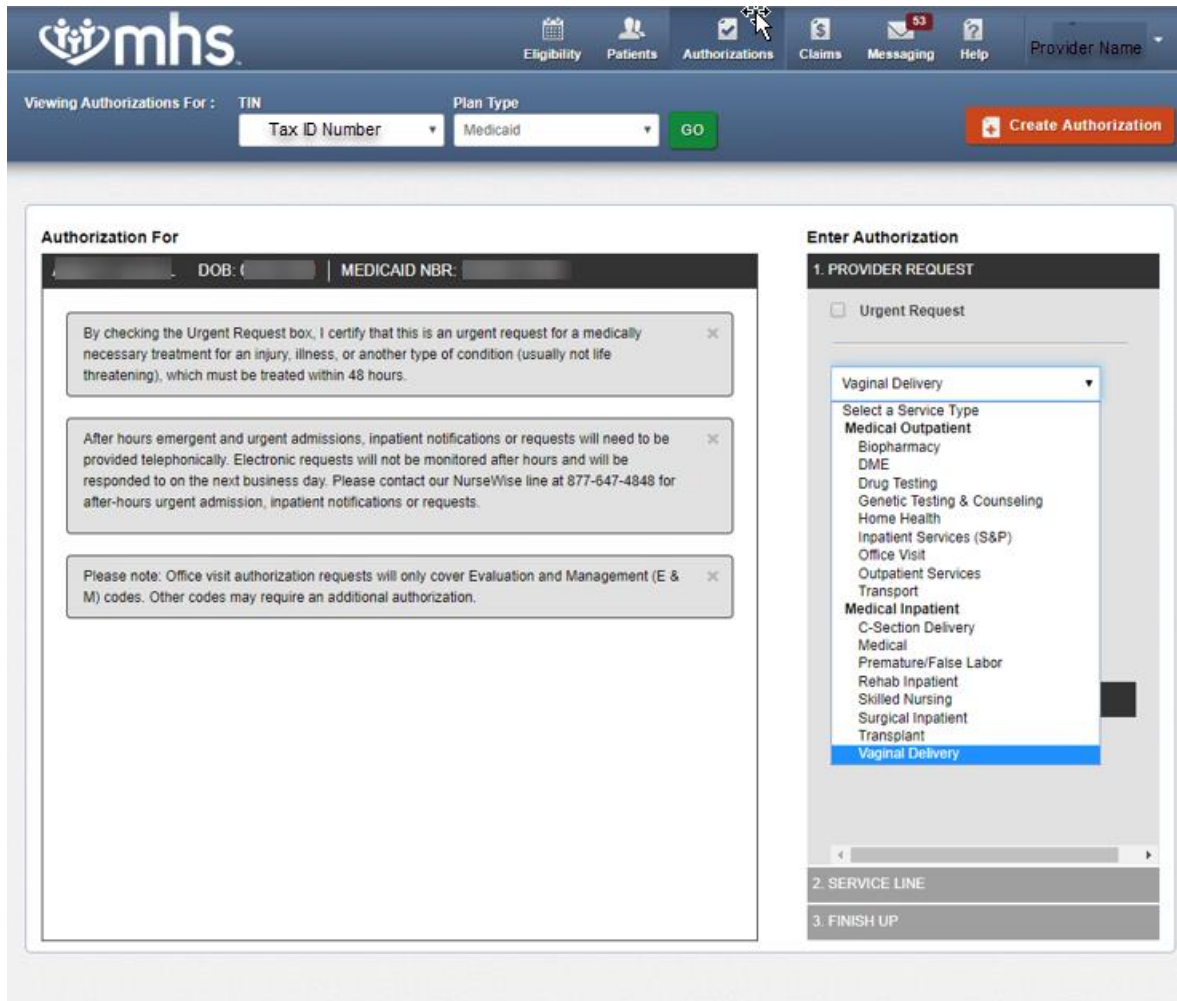
The screenshot shows the MHS web application interface. At the top is the MHS logo and a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a section for 'Viewing Authorizations For :'. It includes a dropdown menu with '1' selected, a 'Medicaid' dropdown, and a green 'GO' button. To the right of this section is an orange button labeled 'Create Authorization', which is highlighted with a red arrow pointing to it. Below the 'Viewing Authorizations For' section is a bar with 'Authorizations', 'Processed', 'Errors', and 'Disclaimer' tabs, and a 'Filter' button on the right.



This screenshot shows the same MHS web application interface, but with the search fields highlighted. The 'Viewing Authorizations For' section is the same. To the right of the 'GO' button are two input fields: 'Member ID or Last Name' and 'Birthdate'. The 'Member ID or Last Name' field contains the text '123456789 or Smith' and the 'Birthdate' field contains the text 'mm/dd/yyyy'. Both fields are highlighted with red arrows. To the right of these fields is an orange 'Find' button. Below the search fields is the same bar with 'Authorizations', 'Processed', 'Errors', and 'Disclaimer' tabs, and a 'Filter' button on the right.

Creating a New Authorization

Select a Service Type



The screenshot shows the MHS Authorization System interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there is a section for "Viewing Authorizations For:" with dropdowns for "TIN" (set to "Tax ID Number") and "Plan Type" (set to "Medicaid"), a "GO" button, and a "Create Authorization" button. The main content area is divided into two columns. The left column, titled "Authorization For", contains fields for "DOB:" and "MEDICAID NBR:", followed by three informational boxes. The right column, titled "Enter Authorization", shows "1. PROVIDER REQUEST" with an "Urgent Request" checkbox and a dropdown menu for "Vaginal Delivery". Below this, there are sections for "2. SERVICE LINE" and "3. FINISH UP".

Authorization For

DOB: MEDICAID NBR:

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.

Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Vaginal Delivery

Select a Service Type

Medical Outpatient

- Biopharmacy
- DME
- Drug Testing
- Genetic Testing & Counseling
- Home Health
- Inpatient Services (S&P)
- Office Visit
- Outpatient Services
- Transport

Medical Inpatient

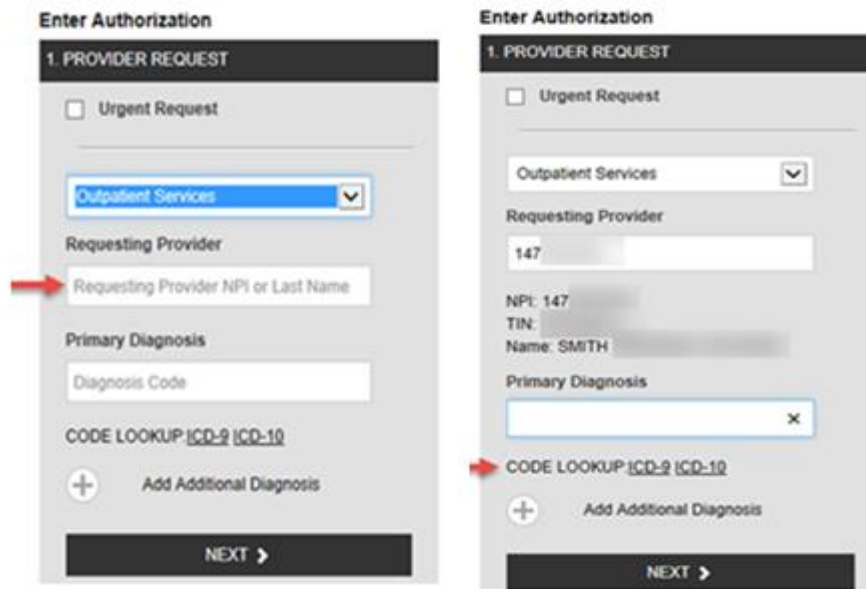
- C-Section Delivery
- Medical
- Premature/False Labor
- Rehab Inpatient
- Skilled Nursing
- Surgical Inpatient
- Transplant
- Vaginal Delivery

2. SERVICE LINE

3. FINISH UP

Creating a New Authorization

Select Provider NPI Add Primary Diagnosis



The image displays two sequential screenshots of the 'Enter Authorization' form, specifically the '1. PROVIDER REQUEST' section.

Left Screenshot: The form is titled 'Enter Authorization' and '1. PROVIDER REQUEST'. It includes an 'Urgent Request' checkbox. Below it is a dropdown menu for 'Outpatient Services'. The 'Requesting Provider' section has a text input field for 'Requesting Provider NPI or Last Name', which is highlighted with a red arrow. The 'Primary Diagnosis' section has a text input field for 'Diagnosis Code'. At the bottom, there is a 'CODE LOOKUP: ICD-9 ICD-10' link, a plus icon to 'Add Additional Diagnosis', and a 'NEXT >' button.

Right Screenshot: This screenshot shows the form after some data has been entered. The 'Requesting Provider' field now contains '147'. Below it, the 'NPI: 147', 'TIN:', and 'Name: SMITH' are displayed. The 'Primary Diagnosis' field is now a search box with a close icon (X). A red arrow points to the 'CODE LOOKUP: ICD-9 ICD-10' link. The 'Add Additional Diagnosis' link and the 'NEXT >' button are also visible.


Creating a New Authorization

 If required Add Additional Procedures

Authorization For

DOB: MEDICAID NBR:

PROVIDER REQUEST

 Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
 Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
 Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
 NPI: 147
 TIN:
 Phone:

Enter Authorization

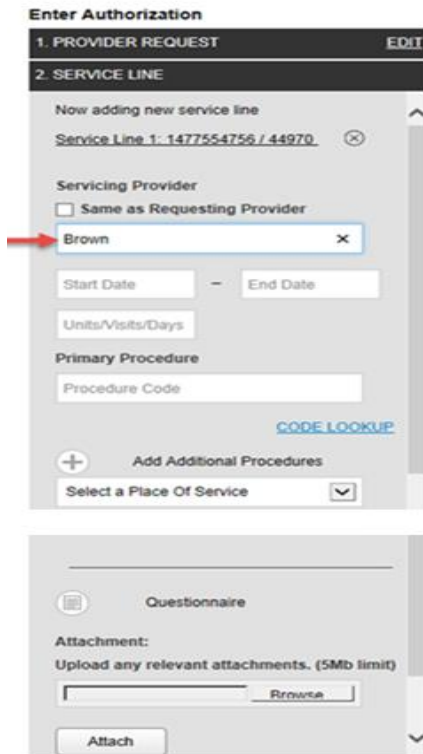
1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN:
 Name: SMITH
 07/14/2015 - 07/24/2015
 1
 Primary Procedure
 44970
 LAPAROSCOPY RUSGICAL
 APPENEDECTOMY
[CODE LOOKUP](#)
 + Add Additional Procedures
 Select a Place Of Service
 Ambulatory Surgical Center
 Outpatient Hospital
 Unspecified
 + Add New Service Line
 NEXT >

Creating a New Authorization

Service Line Details:



Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Service Line 1: 1477554756 / 44970 ✕

Servicing Provider

☐ Same as Requesting Provider

→ Brown ✕

Start Date - End Date

Units/Visits/Days

Primary Procedure

Procedure Code

[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service ▼

📄 Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

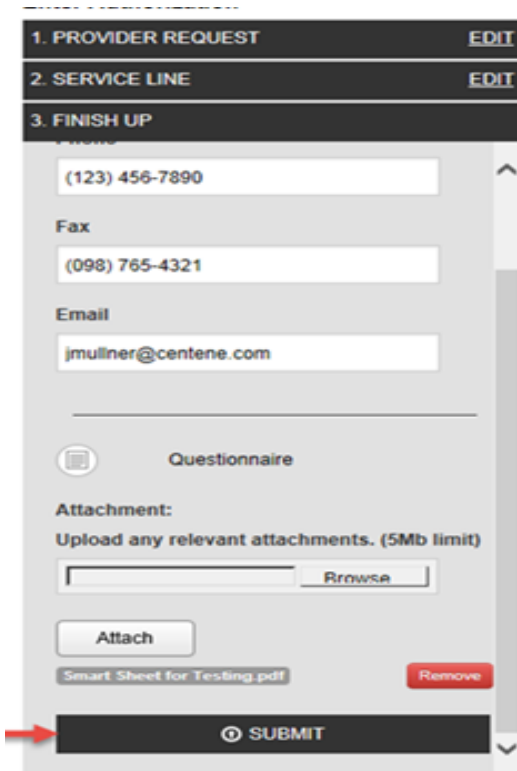
Browse

Attach

- Provider Request will appear on the left side of the screen.
- Update Servicing Provider:
 - Check box if same as Requesting Provider.
 - Update Servicing Provider information if not the same
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure:
 - Code lookup provided.
- Add any additional procedures.
- Add additional Service Line if applicable:
 - All service lines added will appear on the left side of the screen.

Creating a New Authorization

-  Submit a new Authorization:
- **Confirmation number.**



1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Phone: (123) 456-7890

Fax: (098) 765-4321

Email: jmuliner@centene.com

Questionnaire

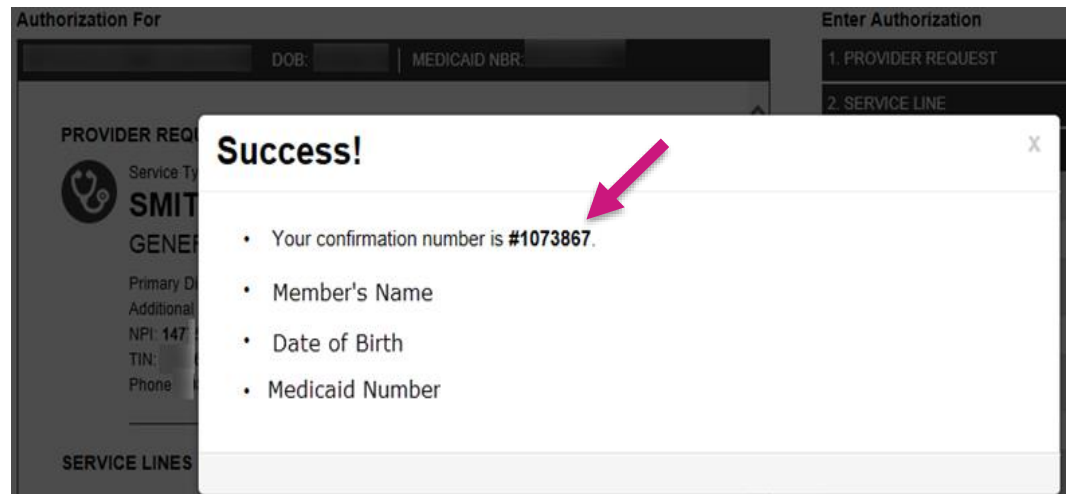
Attachment: Upload any relevant attachments. (5Mb limit)

[Browse](#)

[Attach](#)

Smart Sheet for Testing.pdf [Remove](#)

[SUBMIT](#)



Authorization For

DOB: MEDICAID NBR:

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

PROVIDER REQUEST

Service Type: SMITH

GENERAL

Primary Doctor

Additional

NPI: 147

TIN:

Phone:





SERVICE LINES

Success!

- Your confirmation number is **#1073867**.
- Member's Name
- Date of Birth
- Medicaid Number

Telephone and Fax Authorizations

Telephone Authorization

-  Providers can initiate Prior Authorization via the MHS referral line by calling 1-877-647-4848:
 - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
 - After hours, MHS 24-hour nurse line available to take emergent requests.
-  The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
-  For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process.
-  Please have all clinical information ready at time of call.

Fax Authorization

MHS Medical Management Department at 1-866-912-4245:

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	

← Member ID/RID, DOB
Patient name, **required**

← Medical Diagnosis
code(s) **required**

← Check service category

Please check the requested assignment category below:

- | | | |
|---|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> <i>Purchased</i> | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> <i>Rented</i> | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Fax Authorization

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:

← Enter the **Requesting** provider's information

← Enter the **Rendering** provider's individual NPI#

Fax Authorization

Dates of Service Start Stop		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars

Prior Authorization Denial and Appeal Process

Medical PA Denial and Appeal Process

If MHS denies the requested service:






- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial.

The attending physician has the right to a peer-to-peer discussion with an MHS physician:

- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.
- They must request peer-to-peer within **10 days** of the adverse determination.


****Prior authorization appeals are also known as medical necessity appeals.***

Medical PA Denial and Appeal Process

-  Send Prior Authorization/Medical Necessity Appeals to:
Managed Health Services
Attn: Appeals Coordinator
PO Box 441567
Indianapolis, IN 46244
-  Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider.
-  We will communicate determination to the provider within **20 business days** of receipt.
-  ***A prior authorization appeal is different than a claim appeal request.***
-  ***This process is applicable to members and non-contracted providers.***

Behavioral Health PA Denial and Appeal Process

Medical Necessity Appeals

 Medical Necessity appeals must be received by MHS within 60 calendar days of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal. Medical necessity behavioral health appeals should be mailed or faxed to:

MHS Behavioral Health
ATTN: Appeals Coordinator
12515 Research Blvd, Suite 400
Austin, TX 78701
FAX: 1-866-714-7991

MHS Team

MHS Provider Network Territories

TAWANNA DANZIE

Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS

Beacon Medical Group
Franciscan Alliance
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Parkview Health System
South Bend Clinic

JENNIFER GARNER

Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS

American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
HealthNet
Health & Hospital Corporation of
Marion County
Indiana University Health
St. Vincent Medical Group

NETWORK LEADERSHIP

JILL CLAYPOOL

Vice President, Network
Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

NANCY ROBINSON

Senior Director, Provider Network
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

MARK VONDERHEIT

Director, Provider Network
1-877-647-4848 Ext. 20240
mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

TIM BALKO

Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

MICHAEL FUNK

Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR

Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS

Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.com

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Available online:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory_map_2020.pdf

**Thank you for being our
partner in care.**